RETURN TO WORK EMPLOYER'S JOB DESCRIPTION

Job Title _____ Claim # _____

Employer _____ Claimant _____

Phone # _____ Date _____

Description completed by: _____ Title _____

Essential task description:

Machinery, tools, equipment and personal protective equipment. **(Please submit MSDS if appropriate.)**

PHYSICAL DEMANDS

N/A: Not Applicable
S: Seldom (1-10% of the time)
O: Occasional (10-30% of the time)
F: Frequent (30%-70% of the time)
C: Constant (Over 70% of the time)
WNL: Within normal limits – use for Talking, Seeing and Hearing only

	Frequency	Description of Task
Sitting		
Standing		
Walking		
Driving		
Lifting ( )lb.		
Carrying: ( )lb.		
Pushing/Pulling: ( ) lb.		
Climbing Stairs/Ladders		
Bending/twisting at waist		
Kneeling/squatting		
Crouching/Kneeling		
Crawling		
Reaching above shoulder		
Repetitive Motion		
Handling/Grasping		
Fine Finger Manipulation		
Talking		
Hearing		
Seeing		
Other		

Job Title _____ Claim # _____

Employer _____ Claimant _____

Phone # _____ Date _____

☐ The injured worker can perform this job and can return to work on _____

☐ The injured worker can perform this on a **part-time** basis for _____ hours per day

☐ The worker can be expected to return to regular duty in _____ days/weeks

☐ The injured worker can perform the described job but only with **modifications.** In the comments section indicate the modifications required.

☐ The injured worker cannot perform this job based on the following physical limitations or ***objective medical findings***.

Comments

Possible Modifications

Physician Information

Physician's Address				
City	State	ZIP	Phone	FAX
Date	Printed Signature	Signature		

RESET